DOCUMENT RESUME

ED 477 283 RC 022 899

TITLE	Community Health Advisor Programs. An Issue Paper.
INSTITUTION	National Rural Health Association, Kansas City, MO.
PUB DATE	2000-11-00
NOTE	8p.
AVAILABLE FROM	For full text: http://www.nrharural.org/dc/issuepapers/ipaper17.html.
PUB TYPE	Information Analyses (070) -- Reports - Evaluative (142)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	*Access to Health Care; *Community Health Services; Health Education; *Health Personnel; *Health Promotion; Home Visits; Human Services; *Indigenous Personnel; Lay People; Nonformal Education; *Outreach Programs; Prevention; Rural Areas

ABSTRACT

Third World countries have used community health advisors (CHAs) for many years to deliver health services, health education, and linkages to isolated and underserved communities. In 1998 the National Community Health Advisor Study estimated there were at least 600 such programs in the United States using about 12,500 CHAs. Program activities and target populations vary widely; CHAs' work ranges from volunteer service in health education to actual provision of services. The most significant commonalities of CHA programs are a focus on reaching hard-to-reach populations, use of indigenous workers, and CHA expertise in community knowledge rather than formal education. Results of the 1998 national survey of 281 respondents provided data on rural and urban location of programs, racial and ethnic groups targeted, types of health problems encountered, provision of advocacy services, and types of outreach sites. Most CHAs were paid workers but averaged only 20 hours per week. Examples illustrate typical CHA activities: (1) acting as a bridge between underserved people and service providers (explaining the system to clients and gathering information for providers); (2) providing culturally appropriate health education and information; (3) locating cases, making referrals, and providing followup; (4) helping people with basic needs; and (5) building individuals' capacity to help themselves. Only a few evaluations of CHA programs have been carried out, all with positive results. Serious challenges for programs include inadequate and unreliable funding, lack of legitimacy among professionals, the health care system's lack of emphasis on prevention, and varying levels of CHA training. Recommendations focus on formal recognition of the value of CHAs, better funding, a comprehensive evaluation, and advocacy. (SV)

Reproductions supplied by EDRS are the best that can be made
from the original document.

S DEPARTMENT OF EDUCATION
of Educational Research and Improvement
ATIONAL RESOURCES INFORMATION
CENTER (ERIC)
s document has been reproduced as
eived from the person or organization
ginating it.
or changes have been made to
prove reproduction quality.

nts of view or opinions stated in this
ument do not necessarily represent
cial OERI position or policy.

National Rural Health Association

PERMISSION TO REPRODUCE AND
DISSEMINATE THIS MATERIAL HAS
BEEN GRANTED BY

Julie
Gibson

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

ED 477 283

COMMUNITY HEALTH ADVISOR PROGRAMS

An Issue Paper Prepared by the National Rural Health Association-November 2000

For years health policy discussions have focused on how to extend health insurance to the uninsured, make health services available and simultaneously bring medical costs under control. However, deeply rooted obstacles to access exist even when services are theoretically available and affordable. Poverty, geographic isolation, cultural and ethnic differences, lack of transportation, low literacy, lack of knowledge regarding the need for or availability of health services are barriers to health and social services for millions of unserved and underserved Americans. Availability does not equal utilization.

People who are local, indigenous members and residents of underserved communities are uniquely knowledgeable about their population's needs. Where such individuals are already serving as natural helpers, they communicate to the providers the needs of community members, provide quality health promotion and disease prevention information to the community members and serve as a crucial link between their communities and providers to increase utilization of available preventive health services and to use existing health services appropriately (Kentucky Homeplace, 1994). Oftentimes these workers have access to people who do not want to have anything to do with the formal caregiving systems. For the purposes of this paper, the term "community health advisor" (CHA), will be used to identify lay health outreach workers, but the Center for Disease Control and Prevention (CDCP) identified at least 60 alternative titles, including community health worker, health promoter, family health care advisor, home visitor, natural caregiver, natural helper, peer counseler, promotora, and resource mother.

Background on Community Health Advisor Programs

Third World countries have used lay health workers for many years to deliver health services as well as health education and linkages (Ramprasad, 1988, McCoy, 1994, Bastien, 1990, Robinson, 1990). They have also been a prominent component of the health care systems of some industrialized countries such as Australia, Great Britain and Canada (Moran, 1976, Jacques, 1982, Jay, 1983). Interest in the United States in such programs has waxed and waned, but appears to have been increasing since the mid-'70s (Richter, 1974).

The Centers for Disease Control and Prevention cataloged more than 200 programs in 1994 (CDCP, 1994). CDCP updates the inventory but the proliferation of programs seems to have outpaced their efforts. The National Community Health Advisor Study of 1998 estimates there are at least 600 such

BEST COPY AVAILABLE

programs using approximately 12,500 community health advisors (Rosenthal, 1998).

The range of programs is very wide. Many programs focus on special ethnic or racial population groups such as African Americans and Hispanics. Others focus on specific sectors of the population such as mothers and children or the elderly. Many programs relate only to specific diseases most prominent of which are cancer and cardiovascular disease. There are also programs that deal broadly with health promotion/disease prevention, and injury and violence (CDCP, 1994). A few programs are very comprehensive and deal with families holistically without any categorical program restrictions.

The scope of work for these community health advisors also varies along a continuum from limited volunteer service in health education to the actual provision of services such as the Alaskan Community Health Aides and the services provided by other programs of the Indian Health Service. This policy paper is limited to CHA programs that do not provide direct medical services.

The most significant commonalities of CHA programs are that:

- they are focused on reaching hard-to-reach populations;
- the workers usually are indigenous to the target population; and
- their expertise is in knowing their communities rather than formal education.

What Do We Know About Community Health Advisor Programs?

The national study, which included focus groups, literature review and a survey representing 31 states and the District of Columbia, presented the following survey results from 281 respondents. (Note:the percentages in the following paragraphs do not total 100 percent because respondents could indicate all categories that applied.) Twenty-seven percent of the programs served rural areas, 29 percent served urban areas and 38 percent served both rural and urban areas. The programs, which targeted racial and ethnic clients (or both) were distributed across racial and ethnic categories as follows: 85 percent targeted Hispanic clients; 69 percent were aimed at non-Hispanic whites; 60 percent targeted African Americans; 42 percent included Asian-Pacific Islanders; and 41 percent targeted Native Americans (National Community Health Advisor Study, 1998).

Respondents provided information about the health problems they encounter. More than 50 health problems were identified. Almost half of the programs provide services related to HIV/AIDS (48 percent) and/or cancer (40 percent). Many programs also focused on maternal health and prenatal care (32 percent). Domestic violence was a concern of 26 percent of the programs. In addition, twenty-six percent of the programs provided advocacy services with regard to poverty, housing, food, and employment resources (National Community Health Advisor Study, 1998).

Outreach sites include client homes (74 percent), community centers (72 percent) schools (66 percent), clinics/hospitals (67 percent), religious organizations (50 percent), worksites (40 percent), shelters (35 percent) and migrant labor camps (24 percent) (National Community Health Advisor Study, 1998).

Results of the national survey indicate that between 75 percent and 85 percent of CHAs have paid workers instead of volunteers. The most common wages were from $7.90 to $10.90 per hour or $16,432 to $22,672 for full time work. However, the median number of hours per week was only 20. Only 26 percent of the respondents were employed full time. Fifty percent of them have sick/vacation leave, 49 percent have health benefits, and 34 percent have retirement benefits.

What Do Community Health Advisors Do?

While programs vary in scope and activities, generally the community health advisors provide some or all of the following services that were identified in the national study. The illustrations were written by lay health workers and are intended to give a better sense of the needs of the people and activities of the community health advisors.

Activity 1: CHAs are bridges between unserved and underserved populations and the health and social services they need. They educate community members about how to navigate the health care and social services systems. Specifically, they gather information for medical providers and they translate literal and medical languages.

Example: "One day while making a home visit to an older woman, I noticed two small boys playing outside that could barely see. I asked the boys' mother if they wore glasses and she told me no. The mother told that one child was completely blind in one eye and fifty percent blind in the other eye. I asked her if she would like for me to make an appointment with a specialist and she told me to go ahead. I transported the mother and her two children to their appointment. The doctor felt these children needed to have extensive tests. The mother refused to have the tests done, and told the doctor that she had also refused the tests two years before. When I asked why she didn't want to have the tests done, she said it was because the doctor wanted to "put the children to sleep and put wires behind their eyes.' I asked the doctor to explain the procedure to me and I would explain it to the mother. When she saw it wasn't what she thought it was, she agreed that she would do whatever it would take to help the boys. She couldn't understand it the way the doctor explained it, but she understood the way I explained it. The doctor told me he was happy I was there to explain."

Activity 2: Community health advisors provide culturally appropriate health education and information by teaching concepts of health promotion and disease prevention and helping to manage chronic diseases.

Example: "I received a referral from a health department social worker to help a little boy and his mother. I made a home visit and found out that the 21-year-old mother and 6-month-old son lived with the mother's boyfriend. He has three children of his own from his first marriage. The baby was underweight and the mother needed help with nutrition. She can't cook so her boyfriend cooks all the meals. The baby is six months old and is lying on the floor because he doesn't have a baby bed. There was a big bed but it had no sheets. The baby has not gained any weight in the last three months. I came back to the office and called a family resource center to see if they could help me get a baby bed. They got a bed and sheets. Her boyfriend told me he likes meat loaf but didn't know how to cook it. I asked him if he had any pans to fix it in and he said he didn't. I went to the dollar store and got two pans, an electric mixer, and a measuring cup. Then I went to the store and got the things he needed to make meatloaf. I showed him step by step and gave him a recipe for the meat loaf. A week later, I made another visit and asked if he had made a meat loaf during that week. He said he had made not one meat loaf but SEVEN! So I guess I taught him good. The social worker went and got two weeks' worth of baby food. We made a home visit together and explained to the boyfriend and the mother how to feed the baby. Before we left, the baby ate two jars of baby food. I will work with the mother and boyfriend on nutrition, hygiene and parenting skills, and spending their food stamps."

Activity 3: CHAs assure that people get the services they need through case finding, making referrals and providing follow up.

Example: "I am helping a 77-year-old lady who had not been to the doctor or had medical attention in years. The lady needed a physical, pap, pelvic, etc. I got her into the family practice clinic for her

physical. She needed cataract surgery and I arranged it through the National Eye Care Program and we got them to pay for it. She had hospital costs paid through the state Hospital Care Program. She had to have medicines for her eyes. Community Ministries helped with this. The Lion's Club is paying for her glasses."

Activity 4: CHAs help people with basic needs.

Example: "We received a referral from home health about a family that has a child that has been burnt and also the father had his appendix removed, is diabetic and isn't healing correctly so he is unable to work. The baby is supposed to wear white t-shirts over his burn but had none to wear. We made a home visit finding that this sweet family lives in unsanitary conditions with no water, electricity or gas for the cooking stove. I contacted some places and did some checking and found several white t-shirts along with other clothing items. I took them two gallons of drinking water. The baby has a doctor's appointment at the tertiary hospital. I called and arranged transportation for them. When I made the next home visit, the family told me that if they could pay $90 for an electric bill, they could get their electricity turned on. I suggested contacting the Holy Family Catholic Church for their emergency assistance program."

Activity 5: CHAs build individual and community capacity.

Example: "I have been working with a family member who is pregnant but she never went back to the doctor after the pregnancy was confirmed. I made a few visits explaining why it is so important to go to the doctor for prenatal care. She would tell me she was feeling good and didn't need to see no doctor. It took me awhile, it sure did, but I finally got her to make an appointment to see the doctor. I arranged transportation for her and told her how to set up appointments with the local transit and they would come and pick her up. I gave her the phone numbers of people to call and explained each step to her. I wanted her to be able to do for herself and feel confident and proud that she had learned how to get the transit to come."

How Safe Are Community Health Advisor Programs?

In spite of the number of CHA programs, there has been no comprehensive or rigorous evaluation of such programs at a national level. This is problematic because the absence of convincing data on program processes and outcomes exacerbates the chronic problems with funding which most CHA programs experience. There are a number of reasons for the lack of program evaluations. Most CHA programs do not have the funding or expertise to do a convincing evaluation. Also, the focus of most CHA programs is on clients and time spent completing forms or other evaluation activities is seen as taking time away from clients. And, as can be seen in the preceding examples, CHAs frequently provide a variety of services for a client, which can complicate documentation. Nevertheless, if CHA programs are to become a recognized part of the care giving continuum, proper evaluations must be conducted.

A few of the limited number of evaluations are summarized below. All of these had positive results.

- An assessment of the use of lay health advisors (LHAs) with migrant farmworkers in North Carolina found that mothers with exposure to LHAs were more likely to bring their children in for sick child care, have greater knowledge of health practices and more likely to make the recommended number of prenatal visits (Watkins, et al, 1994).
- An evaluation of a program, which compared mother's compliance with treatment of upper respiratory infections when instructed by physicians, nurses and community health aides found no difference in compliance relative to provider type (Cauffman, 1970).

- Lay health outreach workers increased utilization of preventive services by poor members of the Kaiser Permanente Medical Care Program (Colombo, 1979).
- Seniors who had friendly visits had significantly greater knowledge of community programs for the elderly than those who had not received such visits (Keller, 1988).
- A review of seven home visiting child-health programs found home visitor programs can lead to the following improvements in child health outcomes: increased birth weight, improved prenatal care, improved maternal-infant interaction and improved use of community resources (Chapman, 1990).
- A generic CHA program reduced hospitalization payments for admissions for ambulatory care sensitive conditions from $1,647,200 in the year before the clients enrolled in the CHA program to $233,666 during the year following enrollment. Likewise, emergency room costs were reduced from $20,723 before enrollment to $5,300 after enrollment. The differences were the result of linking clients with these conditions to primary care and preventive services on a routine basis. The conditions included stomach ulcers, hypertension, asthma, heart disease and diabetes (Kentucky Homeplace, 2000).

Conclusions

Community Health Aide programs can make substantial contributions to health care access and improved health status in hard-to-reach populations. The Pew Health Professions Commission studied the use of such workers and came to the following conclusions: CHAs fill an important access gap in the delivery system by demystifying system barriers and by providing motivation. CHAs decrease the cost of care through their work in prevention and promotion by increasing child immunization rates, decreasing incidence of hypertension, smoking cessation and decreased infant mortality and low birth weight. As extensions of primary care teams they can prevent unnecessary reliance on costly emergency department and specialty services. Their effectiveness in improving health care access and quality thereby improves overall community health status, which contributes to community empowerment and growth (Pew, 1994). It should be noted that in an era of welfare reform, CHA programs also offer low-skilled unemployed workers the chance to explore a new occupation.
The Government Accounting Office reached most of the same conclusions stating "Home visiting is a promising strategy for delivering or improving access to early intervention services that can help at-risk families become healthier and more self-sufficient. Evaluations have demonstrated such services are particularly useful when families both face barriers to needed services and are at risk of poor outcomes such as low birth weight, child abuse and neglect, school failure and welfare dependency" (GAO, 1990).

Despite some recognition of the positive contributions of CHA programs, they face serious challenges:

- Most CHA programs are unstable because of inadequate and unreliable funding.
- Other health professionals do not value the work of CHAs because they do not understand what CHAs do or see CHAs as a threat to their own positions.
- The United States health care system is geared toward advanced technology and cures rather than prevention and promotion.
- CHA programs have not been evaluated adequately from a national perspective.
- Training of CHAs is variable in terms of quality and content.

Recommendations for the NRHA

1. NRHA should formally recognize and promote CHA programs as one means of improving access to health and social services for hard-to-reach rural populations.

2. NRHA should favor support for funding CHA programs through public funding sources including Medicaid and Medicare managed care organizations. Consideration should be given to using funds earmarked for outreach in those programs for CHA outreach programs. NRHA should encourage support from the private sector.

3. NRHA should encourage the Office of Rural Health Policy to fund a comprehensive evaluation of CHA programs in rural areas and disseminate the results widely.

4. NRHA should encourage the Centers for Disease Control and Prevention to continue to inventory CHA programs and to establish a national clearinghouse for training and evaluation materials.

5. NRHA should encourage local communities engaged in capacity assessment and health planning to consider developing CHA programs to fill some of the gaps they find both as a means of improving the local health care system but also as a means of working with welfare reform.

REFERENCES

Jaques, D. 1982. The Community Health Concept: the nurse in community health. Nursing in Montreal, April; 6(2):8-10.

Jay, P. 1983. Health for All: A Role for the Community. Journal of the Royal College of Physicians, April; 17(2):93-4.

McCoy D. et al. 1994. Promote the Community Health Worker. South African Medical Journal, Dec; (12):872-3.

Moran, L.J. 1976. Community Health Centre Evaluation. Paper 1: Working patterns of allied health professionals. Australian Family Physician, Mar; 5(2):232-246.

Myers, J. 1996. Kentucky Homeplace Evaluation. University of Kentucky Center for Rural Health, Hazard, Kentucky. Unpublished Report.

Pew Health Professions Commission. 1994. Community Health Workers: Integral Yet Often Overlooked Members of the Health Care Workforce. San Francisco, Calif.:UCSF Center for Health Professions.

Ramprasad, V. 1988. Community Health Workers-An Evolving Force. 1988. World Health Forum, 9(2):229-34.

Richter, Ralph W. , Bengen, Barbara, Alsup, Peggy A., Bruun, Bertel, Kilcoyne, Margaret, Challenor, Bernard D. 1974. American Journal of Public Health, Vol. 64, No. 11, pp 1056-1061.

Rosenthal, E. Lee, Director. 1998. National Community Health Advisor Study, University of Arizona Tuscon, Ariz.

United States General Accounting Office (GAO). 1990. Home Visiting: A Promising Early Intervention Strategy for At Risk Families. Report to the Chairman, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. 1994. Community Health Advisors: Models, Research and Practice. Atlanta, Ga.

NRHA Rural Health Policy Board Approved: 111000

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

ERIC REPRODUCTION RELEASE

I. Document Identification:

Title: Community Health Advisor Programs (RC022899)

Author: National Rural Health Association

Corporate Source:

Publication Date: December 2000

II. Reproduction Release:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, Resources in Education (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Service (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please check one of the following three options and sign the release form.

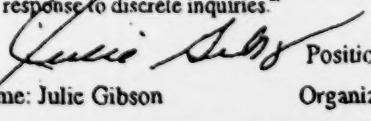
__X__ Level 1 - Permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g. electronic) and paper copy.

____ Level 2A - Permitting reproduction and dissemination in microfiche and in electronic media for ERIC archival collection subscribers only.

____ Level 2B - Permitting reproduction and dissemination in microfiche only.

Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but no option is marked, documents will be processed at Level 1.

Sign Here: "I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries."

Signature:  Position: Communications Director

Printed Name: Julie Gibson Organization: National Rural Health Association

Address: One West Armour Blvd, Suite 203, Kansas City, MO 64111

Telephone No: 816/756-3140

Date: August 9, 2002

III. Document Availability Information (from Non-ERIC Source):

RC022899

If permission to reproduce is not granted to ERIC, or, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

Publisher/Distributor:

Address:

Price per copy: Quantity price:

IV. Referral of ERIC to Copyright/Reproduction Rights Holder:

If the right to grant this reproduction release is held by someone other than the addressee, please complete the following:

Name:

Address:

V. Attach this form to the document being submitted and send both to:

Velma Mitchell, Acquisitions Coordinator
ERIC Clearinghouse on Rural Education and Small Schools
P.O. Box 1348
1031 Quarrier Street
Charleston, WV 25325-1348

Phone and electronic mail numbers:

800-624-9120 (Clearinghouse toll-free number)
304-347-0467 (Clearinghouse FAX number)
mitchelv@ael.org